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Telehealth Services

Medicare has typically placed many restrictions on telehealth services such as geographical and specialty specific limitations. However, in 2019 Medicare expanded its use of telehealth services and provides reimbursement for those encounters traditionally rendered in a face-to-face setting, such as consultations, office visits and psychiatric services. Centers for Medicare and Medicaid Services (CMS) defines these services as "assessment and management services conducted through telephone, internet, or electronic health record consultations," without the patient being physically present.

The Medicare Physician Fee Schedule Final Rule for Calendar Year 2021 went into effect on January 1, 2021. In the Final Rule CMS finalized its proposed policy allowing physicians to provide direct supervision via telehealth until the end of the year in which the PHE ends or December 31, 2021.

This final rule updates policies affecting the calculation of payment rates and includes misvalued codes. It also adds services to the telehealth list including a third temporary category for services added under the PHE, as well as certain other revisions to telehealth services. It also addresses direct supervision as it relates to interactive technology, payment for teaching physicians, and provides clarification on medical record documentation. Additionally, this final rule includes several regulatory actions regarding professional scope of practice for certain non-physician practitioners.

CMS proposed a new category of telehealth services, Category 3, which it would keep on the Medicare telehealth list until the end of the calendar year in which the PHE ends to allow more time to study the benefit of providing these services via telehealth outside the context of a pandemic. An additional set of services would no longer be covered as telehealth services after the PHE ends.
CMS has also finalized its proposal to remove the prohibition on the use of telephones for telehealth services. Telephones, such as smart phones, that fit the definition of "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication" may be used for Medicare telehealth services. CMS did not propose to continue payment for Medicare audio-only visits after the conclusion of the COVID-19 PHE as the agency does not believe it has the authority to waive the requirement for two-way, audio/video communications beyond the PHE.
Within this final rule, CMS has included an interim final rule with comment in order to receive information regarding provision of lengthier audio-only services outside of the COVID-19 PHE, if not as substitutes for in-person services, then as a tool to determine whether an in-person visit is needed, particularly as patients may still be cautious about exposure risks associated with in-person services.

- Consent. Practitioners must continue to obtain patient consent for CTBS (the consent is to notify the patient of copay/cost sharing). CMS stated the timing or manner in which consent is acquired should not interfere with the provision of the service itself. The consent can be verbal or written and can be documented by the billing practitioner or by auxiliary staff under general supervision.

Developed by the AUGS Coding and Reimbursement Committee in 2021.
Disclaimer: The Coding and Reimbursement Committee of the American Urogynecologic Society (AUGS) assists members with the application of governmental regulations and guidelines regarding terminology and CPT/ICD coding in urogynecologic practice. Such information is intended to assist with the coding process as required by governmental regulation and should not be construed as policy sanctioned by AUGS. AUGS disclaims liability for actions or consequences related to any of the information provided. AUGS does not endorse the diagnostic protocol or treatment plan designed by the provider.

- Compliance Tip. When a brief CTBS originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service is considered bundled into that previous E/M service and is not separately billable to Medicare or to the beneficiary (i.e., it is a provider-liable service)

Starting January 1, 2021, the following codes will be available on a permanent basis as part of the covered Medicare telehealth services list:

1. **The Virtual Check-in**

G2012, the virtual check-in, is an example of the new telehealth code set expansion. The descriptor for this code describes the code and qualifies its use. The virtual check-in is a brief (5-10 min), patient-initiated communication by telephone, email or virtual private messaging system to an eligible provider with whom the patient is established, to discuss a problem in order to see if a face-to-face encounter is necessary. The definition of "established patient" has not changed.

The virtual check-in cannot be the result of an evaluation and management (E/M) service within the previous 7 days, nor can it lead to a face-to-face encounter within the next 24 hours. If it overlaps those qualifications, it will be bundled into the face-to-face encounter and not paid separately.

G2012 takes the place of 99441, which was similar in description, but included only telephonic technology.

G2012 requires the patient be informed of the chargeable encounter and provide verbal permission to proceed with the encounter during each instance because a patient co-payment may apply, dependent on the patient's insurance contract. No frequency limit or documentation requisites have been defined except medical necessity and confirmation of verbal consent. This encounter may only be used by the billing practitioner and excludes ancillary staff. Please note: **The medical record must reflect the patient's verbal consent for each instance of communication in order to bill for the service.** Keep in mind as stated above, **only established patients** are eligible for this service.

2. Pre-Recorded Patient Information

CMS is also authorizing payment for review and evaluation of pre-recorded patient information, so called "store and forward" video or imaging technology, under the code **G2010**. Limitations are similar to the virtual check-in code, i.e. it must be patient-generated, cannot be within 7 days after or 24 hours before a face-to-face meeting, and verbal or written consent must be documented with each episode. Additionally, follow up to the patient by telephone, audio/visual technology, or secure text messaging or email within 24 hours must be performed by the provider. Again, this service is billable only for established patients.

3. Extended Audio Only Assessment

On an interim basis, for the duration of 2021, CMS created HCPCS code G2252 for extended services delivered via synchronous communications technology, including audio-only (e.g., virtual check-ins). The service is considered to be a communication technology-based service (CTBS) and is subject to all the other requirements of CTBS.

G2252 is described a b*rief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.* G2252 has higher reimbursement than the current more limited duration virtual check-in code. The code is intended for situations when the acuity of a patient's problem is not necessarily likely to warrant an in-person visit, but when additional time is needed to make this assessment. Also, while the audio only telehealth codes currently approved subject may only be used during the PHE, this code would extend beyond the PHE. The communication technology must be synchronous and is subject to the same billing requirements as the other virtual check-in codes. CMS will consider whether this interim policy should be adopted permanently.

This code has similar rules as G2010 and G2012 and is for longer time periods. When phone calls are no longer paid services after the end of the PHE, it could be used for phone calls.

4. Interprofessional Internet Consultation

Six additional telehealth service codes reimbursable by CMS include interprofessional telephone/internet/electronic consultations without the patient being present. These codes are meant to supplant the need for face-to-face interaction by the patient with the consulting physician. **99451 and 99452**, Interprofessional telephone/internet/electronic health record assessment and management services may be submitted by the consulting and consultative physician for consultation performed via electronic health record. 99451 does not require written report to the patient's requesting provider, while 99452 does require this. These codes are time-based and should document patient consent for each consultation due to patient cost-sharing requirements.

Four similar codes: **99446, 99447, 99448, 99449,** are utilized when a consulting physician performs an interprofessional consultation for an established patient from a treating physician via telephone/internet/electronic health record assessment. Again, these codes are time-based, and the consulting physician is required to supply a consultation document to the treating physician for each code.

Code Differences

99446-99449 require verbal and written feedback and over half of the time must be spent in the verbal/electronic feedback format. *"The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion."* 99451-99452 doesn't necessitate the interprofessional verbal/electronic communication component as consultation may involve EHR interaction only and may be billed if more than 50% of the time involves data analysis with only 99452 requiring a written report to the requesting provider.

Telehealth Service Code Comparison:

Code	Provider	Timing
99446	Consulting	5-10 minutes
99447	Consulting	11-20 minutes
99448	Consulting	21-30 minutes
99449	Consulting	>30 minutes
99451	Treating/requesting	5-29 minutes

Developed by the AUGS Coding and Reimbursement Committee in 2021.

99452	Treating/requesting	30 minutes

Codes **99441, 99442,** and **99443**, evaluation and management codes by telephone only, are currently CMS non-covered services. Other telehealth codes involving remote physiologic monitoring of chronically ill patients, opioid substance abuse counseling, and other indications extend beyond the normal scope of urogynecology and are not covered in this fact sheet.

Clinical Case Scenario

A 69-year-old female goes to her gynecologist complaining of pelvic pain with urinary frequency and urgency, and nocturia 6 times nightly. A urine culture showed no growth, but a urinalysis showed numerous white cells and red blood cells. Further workup included a CT scan, cystoscopy and urodynamic exam. The gynecologist suspects interstitial cystitis/bladder pain syndrome (IC/BPS) but needs help with the diagnosis and treatment protocols. The patient does not want to travel the 100 miles to the nearest urogynecologist. The treating gynecologist has a relationship with the urogynecologist and contacts him with the patient's permission via secure, real-time internet audio visual technology, and goes over the history, physical findings and transmits the pictures of the CT, cystoscopy and urodynamics. The consulting physician confirms the likely diagnosis and provides the step-wise treatment protocols for IC/BPS with the gynecologist. The entire transmission takes 21 minutes.

In this scenario the treating gynecologist will be able to submit code **99451.** The consulting urogynecologist will submit **99448** and send a formal document to the gynecologist regarding the consultation findings and advice rendered. One might think that the urogynecologist may also submit **G2010** in this case as well; however, this code would not apply because the service was not patient initiated but initiated by the treating provider.

5. G2211 Visit Complexity Associated with Certain Office/Outpatient E/Ms

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to an evaluation and management visit, new or established)

6. G2212 prolonged services code

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)

OF SPECIAL NOTE IS TELEHEALTH SUPERVISION OF RESIDENTS

In addition, for residency training sites and teaching settings outside of a metropolitan statistical area (MSA), CMS made permanent the policy allowing teaching physicians to use interactive, real-time audio/video, excluding audio-only, to interact with the resident through virtual means to meet the requirement that they are present through the key portion of the service. The flexibility still

expires after the end of the PHE for teaching settings within an MSA. However, in an attempt to increase beneficiary access to Medicare-covered services in rural areas and to expand training opportunities for residents in rural settings, CMS made the flexibility permanent outside of MSAs. The medical record must indicate how the teaching physician was present to the resident during key portions of services. The flexibility provided by the Final Rule does not apply in the case of surgical, high-risk, interventional, or other complex procedures; services performed through an endoscope; or anesthesia services. The flexibility expires for teaching settings within an MSA following the end of the PHE.

CMS is allowing an attending to be present via real-time audio/visual communication in supervising an E/M service provided by a resident. The teaching physician must be present for the key/critical components using audio/visual communication. Phone is insufficient. CMS states that the patient's medical record: *"must clearly reflect how and when the teaching physician was present during the key portions of the service, in accordance with our regulations.*

CMS also has advice about what to do it the video call with the attending drops.
"We also expect that, if the teaching physician is virtually present and bills for services during which there is a disruption to the virtual connection between the teaching physician and the resident who is with the patient, the encounter would be paused until the connection resumes, or the appointment would be rescheduled. CMS confirmed that under the primary care exception, the attending may supervise the service using audio/visual communication during the public health emergency.

REVIEW OF TELEHEALTH UPDATES BY CMS FOR 2021

- Physicians and other qualified healthcare providers may furnish RPM (Remote Patient Monitoring) services to remotely collect and analyze physiologic data from patients with acute conditions as well as patients with chronic conditions.
- CMS clarified that 20 minutes of time required for 99457 and 99458 can include time for furnishing care management services as well as interactive communication.
- CMS will allow for RPM services furnished to new and established patients for the duration of the PHE and only to an established patient after the COVID-19 PHE ends.
- The flexibilities related to RPM were extended through the end of the COVID-19 PHE.
- As a result, at the end of the COVID-19 PHE, RPM services must be furnished only to an established patient and must include at least 16 days of data collection in a 30-day period.
- CMS **did not permanently extend the Medicare telehealth geographic and site of service originating site restrictions** (section 1834(m)), which temporarily allows Medicare beneficiaries across the country to receive care from their homes, citing a lack of statutory authority to do so. Therefore, the waivers in place will last only during the COVID-19 PHE.
- Medicare telehealth visits to nursing facility settings are expanded from once every 30 days to **once every 14 days**.
- Telehealth rules do not apply when the beneficiary and the practitioner are in the same location, even if audio/visual technology assists in furnishing a service.
- CMS finalized its proposal to allow direct supervision to be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021.

- The following codes, added temporarily during the PHE, will remain on the approved telehealth list after the PHE ends:
    - Group Psychotherapy (CPT code 90853).
    - Psychological and Neuropsychological Testing (CPT code 96121).
    - Domiciliary, Rest Home, or Custodial Care services, Established Patients (CPT codes 99334-99335).
    - Home Visits, Established Patient (CPT codes 99347-99348).
    - Cognitive Assessment and Care Planning Services (CPT code 99483).
    - Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211).
    - Prolonged Services (HCPCS code G2212).
- The Final Rule also expands the scope of practitioners that may provide services through telehealth and receive reimbursement.
- The Final Rule permits, on a temporary basis, coverage of "incident-to" services ordinarily requiring direct supervision. Per the Final Rule, virtual supervision by a physician or non-physician practitioner using interactive audio/visual real-time communications technology will meet the definition of "direct supervision."

RVU's

Code	RVUs	Reimbursement
G2010	0.18	6.28
G2012	0.25	8.72
99446	0.35	12.21
99447	0.70	24.43
99448	1.05	36.64
99449	1.40	48.85
99451	0.70	24.43
99452	0.70	24.43

Telemedicine Terms

Distant or Hub site: Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating or Spoke site: Location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

Asynchronous or "Store and Forward": Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

Medical Codes: States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services.

Developed by the AUGS Coding and Reimbursement Committee in 2021.

Telehealth (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.
Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

References:

https://www.federalregister.gov/public-inspection/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

AMA quick guide to telemedicine in practice

https://www.ama-assn.org/topics/telehealth-laws-regulations-policies